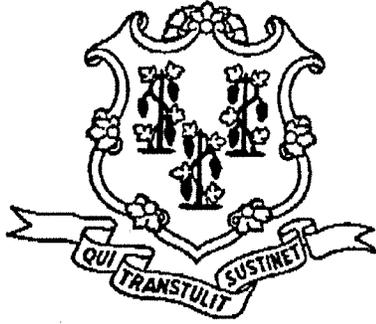


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	
Address (No. & Street, City, State, Zip Code) 89 Weid Drive Naugatuck CT 06770	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 2182-C	RHNS	(Specify)	Medicare Provider No. 07-5390
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Medicaid Provider Numbers:	CCNH 2182-C	RHNS	ICF-MR
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For Department Use Only

Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Number Assigned	Signed and Notarized	Date Received

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General Information

Name of Facility (as licensed) Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	License No. 2182-C	Report for Year Ended 9/30/2017	Page 1	of 37
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Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center [facility name] for the cost report period beginning October 01, 2016 and ending September 30, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under penalties of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator) <i>Thomas Walkuski</i>		Date <i>2/9/18</i>	Signed (Owner) <i>[Signature]</i>		Date <i>2/9/18</i>
Printed Name (Administrator) Thomas Walkuski			Printed Name (Owner) Lawrence G Santilli		
Subscribed and Sworn to before me:	State of <i>CT</i>	Date <i>2-9-18</i>	Signed (Notary Public) <i>Xina Seapalmyer</i>	Comm. Expires <i>6/30/21</i>	
Address of Notary Public			<i>505 Penfield Hill Rd Portland, CT 06480</i>		

(Notary Seal)



**MYERS AND
STAUFFER** LLC
CERTIFIED PUBLIC ACCOUNTANTS

December 11, 2013

Mr. Michael E. Mosier
Chief Financial Officer
Athena Health Care Systems
135 South Road
Farmington, CT 06032

Subject: Alternative Annual Report Approval

Dear Mr. Mosier:

This letter is a follow-up to your verbal approval regarding your request for alternative annual report utilization. We have reviewed your request for approval of the Athena Health Care Systems version of the 2013 Annual Report for the State of Connecticut. Based on our review, your version of the annual report has been approved.

It is not necessary to request approval on an annual basis. This approval will remain in effect until modifications have been made to the Annual Report by the Department of Social Services. The provider community will be notified should such changes occur. At that time, you will be required to submit a new request for approval based on the modified annual report.

Should you have any questions, please feel free to contact me at (860) 687-0790.

Sincerely,

Brittany L. Hester, Administrative Assistant

CC: Claudette B. Pickens, CPA

CC: Chris Lavigne

State of Connecticut
Department of Social Services
 25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	Period Covered:	From 10/1/2016	To 9/30/2017	
Address of Facility 89 Weid Drive Naugatuck CT 06770				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date 2/9/2018		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid..... \$				
2. Laundry wages paid..... \$				
3. Housekeeping wages paid..... \$				
4. Nursing wages paid..... \$				
5. All other wages paid..... \$				
6. Total Wages Paid \$				
7. Total salaries paid..... \$				
8. Total Wages and Salaries Paid (As per page 10 of Report) \$				

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-729-9889	Report for Year Ended 09/30/17	Page 2	of 37
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Name of Facility (as shown on license) Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	Address (No. & Street, City, State, Zip) 89 Weid Drive Naugatuck CT 06770
--	---

License Numbers:	CCNH 2182-C	RHNS	(Specify)	Medicare Provider No. 07-5390
------------------	-----------------------	------	-----------	---

Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)	

Type of Ownership (Check appropriate box)			
<input type="checkbox"/> PROPRIETORSHIP	<input checked="" type="checkbox"/> LLC	<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> PROFIT CORP.
<input type="checkbox"/> NON-PROFIT CORP.	<input type="checkbox"/> GOVERNMENT	<input type="checkbox"/> TRUST	

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If "Yes," explain fully.
--	------------------------------	--	--------------------------

Administrator		
Name of Administrator Linda Garcia	Nursing Home Administrator's License No.:	1064

Other Operators/Owners who are assistant administrators (full or part time) of this facility.	
Name	License No.:
Not Applicable	

**General Information and Questionnaire
 Corporate Owners**

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	License No. 2182-C	Report for Year Ended 9/30/2017	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated	

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each

Not Applicable			

Names of Stockholders Owning at Least 10% of Shares			

General Information and Questionnaire
Individual Proprietorship

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	License No. 2182-C	Report for Year Ended 9/30/2017	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

Not Applicable

**General Information and Questionnaire
 Related Parties***

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	License No. 2182-C	Report for Year Ended 9/30/2017	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? Yes No If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Miscellaneous Facilities	Various	<input checked="" type="checkbox"/>	<input type="checkbox"/>	>98%	Interfacility Loans	Page 33, A2		
Athena Health Care Systems	135 South Road Farmington, CT 060632	<input checked="" type="checkbox"/>	<input type="checkbox"/>	>50%	Management Fee	Page 17	\$213,324	\$210,045
Athena Health Care 401k	135 South Road Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>		Facility participates in common 401k plan			
Athena Health Care Systems	135 South Road Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	>50%	Workers Comp Captive	Page 15 1a	\$455,239	\$455,239
Athena Health Care Insurance	135 South Road Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>		Health Insurance	Page 15 1a5	\$1,530,585	\$1,530,585
Athena Health Care Systems	135 South Road Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	>50%	See Attached	See Attached		
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					

* Use additional sheets if necessary.

** Provide the percentage amount of revenue received from non-related parties.

Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center
 RELATED PARTIES QUESTIONNAIRE
 PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included In Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No	%**				

Athena Health Care Systems

135 South Road
 Farmington, CT

X		>50%
---	--	------

Insurance
 Office Supplies, Health Insurance
 Employee Relations,
 Other Advertising, Lobbying
 Payroll Service Fees, Data Processing Fees,
 Repairs & Maintenance,

Pg 15 1a1
 Pg 15 1a5, 1g
 Pg 16 l3
 Pg 16 m3, m13
 Pg 22 6a,
 Pg 32 C5,

\$42,061

**General Information and Questionnaire
 Basis for Allocation of Costs**

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	License No. 2182-C	Report for Year Ended 9/30/2017	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary.....	Number of meals served to residents
Laundry.....	Number of pounds processed
Housekeeping.....	Number of square feet serviced
Nursing.....	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants.....	Number of hours of resident care provided by EACH specialist (See listing page 13)
Maintenance and operation of plant.....	Square feet
Property costs (depreciation).....	Square feet
Employee health and welfare.....	Gross salaries
Management services.....	Appropriate cost center involved
All other General Administrative expenses.....	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? Yes No If "No," explain fully why such allocation was not made.

Not Applicable

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

Not Applicable

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

Yes No If "No," explain fully why such allocation was not made.

Not Applicable: No Non-Nursing Home Cost Centers

General Information and Questionnaire Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center		License No. 2182-C		Report for Year Ended 9/30/2017			Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
LEAF	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Copier	02/08/17	48 months	\$14,395	\$14,395	
Pitney Bowes P.O. Box 856390, Louisville, KY 40285	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Postal Equipment	12/10/10	66 Months	\$1,091	\$1,091	
Hewlett Packard Financial Services, PO Box 402582, Atlanta, GA	<input type="checkbox"/>	<input checked="" type="checkbox"/>	PCC Equipment	06/24/13	60 months	\$7,043	\$7,043	
Hewlett Packard Financial Services, PO Box 402582, Atlanta, GA	<input type="checkbox"/>	<input checked="" type="checkbox"/>	PCC Equipment	05/22/15	38 months	\$2,025	\$2,025	
Webster Capital Finance P.O. Box 330 Hartford, CT 06141-0330	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Telephone System	08/19/13	36 months	\$7,433	\$7,433	
	<input type="checkbox"/>	<input type="checkbox"/>						
	<input type="checkbox"/>	<input type="checkbox"/>						
	<input type="checkbox"/>	<input type="checkbox"/>						
	<input type="checkbox"/>	<input type="checkbox"/>						
	<input type="checkbox"/>	<input type="checkbox"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ? <u>Not Applicable - No Vehicles</u> <input type="checkbox"/> Yes <input type="checkbox"/> No Total ***							\$31,987	

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.



RENTAL AGREEMENT

1720A Crete Street, Moberly, MO 65270
Phone: 800-662-3759, Fax: 800-426-2626

CUSTOMER LEGAL NAME: Athena Health Care Associates Inc dba Beacon Brook Health Care
Billing Address: 89 WEID DRIVE, Naugatuck, CT 06770
EQUIPMENT DESCRIPTION: (indicate quantity, new or used and include make, model, serial # and all attachments - see below and/or attached Schedule A)
Unit Quantity, Description of Equipment, Make and Type, Model Number, Serial Number

TERMS AND CONDITIONS

In this agreement ("Rental"), "we," "our," and "us" refers to LEAF Capital Funding, LLC and "you" and "your" refer to the Customer. You agree to rent the Equipment from us upon the following terms and conditions:

- 1. RENTAL PAYMENTS AND TERM: The Rental is enforceable on you upon your execution. The term of the Rental shall commence on the date the Equipment is delivered to you ("Rental Commencement Date").
2. DELIVERY, ACCEPTANCE, USE AND REPAIR: You are responsible for Equipment delivery and installation. You unconditionally accept the Equipment upon the earlier of (a) your oral or written acceptance of the Equipment, or (b) 10 days after delivery of the Equipment.
3. INDEMNIFICATION: You agree to indemnify, defend and hold us harmless from and against any losses, damages, penalties, claims and suits, including attorneys' fees and expenses related to the ordering, manufacture, installation, ownership, condition, use, rental, possession, delivery or return of Equipment.
4. RENTAL EXPIRATION, RENEWAL: Unless you notify us at least 90 days prior to the expiration of the Rental of your election to return the Equipment, this Rental will renew on a month-to-month basis at the same monthly Rental Payment until you provide us with at least 90 days notice and return the Equipment.
5. LATE FEES AND CHARGES: If any amount is not paid within five (5) days of when due, you agree to pay us a late charge equal to the lesser of 10% of the amount past due or the maximum legal amount.
6. NO WARRANTY: We do not manufacture the Equipment and you have selected the Equipment and the supplier. WE MAKE NO EXPRESS OR IMPLIED WARRANTIES, INCLUDING THOSE OF MERCHANTABILITY OR FITNESS FOR A PURPOSE AND ARE NOT RESPONSIBLE FOR CONSEQUENTIAL OR INCIDENTAL DAMAGES.
7. INSURANCE, RISK OF LOSS: You bear all risk of loss or damage to the Equipment from its order until it is returned in the required condition ("Risk Period").

interests). If we obtain such insurance, you will pay us an additional amount for the cost of such insurance and an administrative fee, the cost of which may be more than the cost to obtain your own insurance and on which we may make a profit.

- 8. OWNERSHIP AND TAXES: We own the Equipment (excluding licensed software). If you are deemed to own it, you grant us a security interest in the Equipment. You authorize us to file UCC financing statements to confirm our interest. You will pay, when due, all taxes, fines and penalties relating to the purchase, use, renting and/or ownership of the Equipment. If we pay any taxes (including property tax), fees or penalties on your behalf, you will pay us the amount we paid plus an administrative fee. You agree to pay us the documentation fee specified above or if not so specified, the greater of either \$125 or 0.5% of the Equipment cost. If we require an Equipment site inspection, or you request administrative services, you agree to reimburse our costs.
9. DEFAULT: If you or any guarantor do not pay us any amount within ten (10) days of its due date, or breach any terms of this Rental, any guaranty or any license relating to the Equipment, you will be in default. If you default, we may require you to do any combination of the following: (a) immediately pay all amounts then due, plus the present value of the remaining Rental Payments, Interim Rent and residual value of the Equipment, as determined by us, discounted at an annual rate of 3%; (b) return all of the Equipment; (c) allow us to repossess the Equipment; or (d) use any and all remedies available to us under applicable law. If you default, you agree to pay the cost of repossession and our attorney's fees and costs. In addition to all other charges and as reimbursement for expenses incurred and not as a penalty, we may require you to reimburse us for the phone calls, letters, and any additional expense incurred in the collection or servicing of this Rental to you. If we take possession of the Equipment, we may sell or otherwise dispose of it with or without notice, at a public or private sale, and apply the net proceeds (after we have deducted all costs related to the sale or disposition of the Equipment) to the amounts that you owe us. You agree that if notice of sale is required by law, 10 days' notice shall constitute reasonable notice. You remain responsible for any amounts that are due after we have applied such net proceeds. We may apply any security deposits to your obligations and if you do not default, the balance will be refunded without interest.
10. ASSIGNMENT: You have no right to sell or assign the Equipment or Rental. We may sell or assign our rights in the Rental and/or Equipment and the new owner will have all our rights but will not be subject to any claim or defense you have against us.
11. ARTICLE 2A: You agree this Rental is a "finance lease" as defined in Article 2A of the Uniform Commercial Code. You waive all rights and remedies conferred upon a lessee by Article 2A (508-522) of the UCC. You have received a copy of the Supply Contract or been informed of the identity of the Supplier and you may have rights under the Supply Contract and may contact the Supplier for a description of those rights.
12. CREDIT INFORMATION: You authorize us or any of our affiliates to obtain credit bureau reports, and make other credit inquiries that we deem necessary.
13. CHOICE OF LAW: THIS RENTAL WILL BE GOVERNED BY PENNSYLVANIA LAW. YOU CONSENT TO JURISDICTION IN THE STATE OR FEDERAL COURTS IN PENNSYLVANIA AND WAIVE ANY RIGHT TO A TRIAL BY JURY.
14. MISCELLANEOUS: This Rental is the parties' entire agreement and can be amended only in writing signed by both parties. This Rental may be executed in counterparts (manually or by electronic means) and, when transmitted to us shall be binding upon you for all purposes. This Rental is not binding on us until we sign it. You agree not to raise as a defense to the enforcement of this Rental that it was executed or transmitted to us by electronic means. You will use the Equipment only for business purposes and not for personal, family or household use.

ACCEPTED BY CUSTOMER: Athena Health Care Associates Inc dba Beacon Brook Health Care
Print Name: Ryan Balowski Title: IT
Customer Authorized Signature: [Signature] E-Mail Address: rbalowski@athenahc.com Date: 2/8/17

PERSONAL GUARANTY: Undersigned guarantees that Customer will make all payments and perform all other obligations under the Rental when due. Undersigned agrees that this is a guaranty of payment and not of collection, and that we can proceed directly against undersigned without first proceeding against Customer or the Equipment. Undersigned also waives all suretyship defenses and notification if the Customer is in default and consents to any extensions or modifications granted to Customer. Undersigned will pay us all expenses (including attorneys' fees) we incur in enforcing our rights against undersigned or Customer. If more than one person signs this guaranty, each agrees that his/her liability is joint and several. Undersigned authorizes us and our affiliates to obtain credit bureau reports and make inquiries regarding undersigned's personal credit. You consent to jurisdiction in the State or Federal courts in Pennsylvania and expressly waive any right to a trial by jury.

SIGNED X _____ Print Name: _____ E-Mail Address: _____
Accepted by: LEAF CAPITAL FUNDING, LLC By: _____ Title: _____ Date: _____



**SCHEDULE A TO RENTAL AGREEMENT
(EQUIPMENT DESCRIPTION)**

Rental Application No.: **388726**

QNT	Equipment Description	New/Used	Make	Model	Serial Number
-----	-----------------------	----------	------	-------	---------------

Location: 89 WEID DRIVE, NAUGATUCK, CT 06770

8	Xerox WorkCentre 3655 Copier Systems	New	Xerox	WorkCentre 3655	
1	Xerox WorkCentre 7970 Copier System	New	Xerox	WorkCentre 7970	
1	Xerox WorkCentre 5875 Copier System	New	Xerox	WorkCentre 5875	

Model#	Serial#
Xerox WC7970	BOW869808
Xerox WC5875	EX9662165
Xerox WC3655	C7X275039
Xerox WC3655	C7X271868
Xerox WC3655	C7X271763
Xerox WC3655	C7X271766
Xerox WC3655	C7X271757
Xerox WC3655	C7X271762
Xerox WC3655	C7X271767
Xerox WC3655	C7X374006

CUSTOMER: Athena Health Care Associates Inc dba Beacon Brook Health Care

LEAF CAPITAL FUNDING, LLC

BY: Ryan Balowski
 PRINT NAME: Ryan Balowski
 TITLE: IT
 DATE: 2/8/17

BY: _____
 PRINT NAME: _____
 TITLE: _____
 DATE: _____

General Information and Questionnaire
Accounting Basis

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	License No. 2182-C	Report for Year Ended 9/30/2017	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual Cash Modified Cash

Is the accounting basis for this period the same as for the previous period? Yes No If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Marcum LLP	555 Long Wharf Drive New Haven, CT
2 Marcum LLP	555 Long Wharf Drive New Haven, CT
3	
4	

Services Provided by This Firm (*describe fully*)

1 2017 Tax Return & Audit	\$ 26,125
2 9/30/16 Medicare Cost Report	\$ 2,700
3	\$ -
4	\$ -
	Charge for Services Provided
	\$28,825

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.

Yes No **Pg 15, Line1d**

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman, Gruder, & Woods, LLC	203-899-8900
2 Treasurer, State of CT	860-231-2442
3 Murtha Cullina LLP	860-240-6000
4 Michael Mormile (State of CT Probate Court)	203-720-7046
5	

Address (*No. & Street, City, State, Zip Code*)

- 1 **200 Connecticut Avenue Norwalk, CT 06854**
- 2 **186 Newington Road West Hartford, CT 06110**
- 3 **City Place 185 Asylum Street Hartford, CT 06103**
- 4 **229 Church Street Naugatuck, CT 06770**
- 5

Services Provided by This Firm (*describe fully*)

1 A/R Collections (Disallow)	\$ 1,769
2 Conservator Request (Disallow)	\$ 255
3 Annual report Audit Letter \$1,436 (Allow) Misc Issues 1,870 (Disallow)	\$ 3,306
4 Conservator Request (Disallow)	\$ 42
5	\$ -
	Charge for Services Provided
	\$5,372

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.

Yes No **Pg 15, Line1e**

Schedule of Resident Statistics

Name of Facility		License No.			Report for Year Ended				Page	of			
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center		2182-C			09/30/17				8	37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period.....	126	126			126	126			126	126			
B. On last day of THIS report period.....	126	126			126	126			126	126			
2. Number of Residents													
A. As of midnight of PREVIOUS report period.....	117	117			119	119			117	117			
B. As of midnight of THIS report period.....	122	122			121	121			122	122			
3. Total Number of Days Care Provided During Period													
A. Medicare.....	6,178	6,178			4,861	4,861			1,317	1,317			
B. Medicaid (Conn.).....	35,380	35,380			26,205	26,205			9,175	9,175			
C. Medicaid (other states).....													
D. Private Pay.....	1,656	1,656			1,265	1,265			391	391			
E. State SSI for RCH.....													
F. Other (Specify) Managed Care	592	592			488	488			104	104			
G. Total Care Days During Period (3A thru F).....	43,806	43,806			32,819	32,819			10,987	10,987			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days.....	197	197			181	181			16	16			
B. Other Bed Reserve Days.....	43	43			19	19			24	24			
5. <i>Total Resident Days (3G + 4A + 4B).....</i>	44,046	44,046			33,019	33,019			11,027	11,027			

Schedule of Resident Statistics (Cont'd)

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center			License No. 2182-C			Report for Year Ended 9/30/2017			Page 9	of 37			
4. Were there any changes in the certified bed capacity during the report year? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)	
				(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change.....													
2nd change.....													
3rd change.....													
4th change.....													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	12		100		4		6						
Per Diem Rate													
a. One bed rm.	576.67		230.70		527.00		420.82						
b. Two bed rms.	576.67		230.70		512.00		420.82						
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									8,447	8,447			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									3,215	3,215			
2. Restorative Treatments													
C. Other									16,470	16,470			
D. Total Physical Therapy Treatments									28,132	28,132			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									1,985	1,985			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									533	533			
2. Restorative Treatments													
C. Other									2,457	2,457			
D. Total Speech Therapy Treatments									4,975	4,975			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									6,620	6,620			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									2,881	2,881			
2. Restorative Treatments													
C. Other									15,911	15,911			
D. Total Occupational Therapy Treatments									25,412	25,412			

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/2017	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	121,637	2,100				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	255,702	10,512				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	53,882	2,070				
c. Dietary Workers	427,533	30,855				
6. Housekeeping Service						
a. Head Housekeeper	29,733	1,143				
b. Other Housekeeping Workers	258,682	20,435				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	60,504	2,132				
b. Other Maintenance Workers	59,678	3,578				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	105,350	8,528				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	218,300	4,307				
b. RN						
1. Direct Care	553,771	15,716				
2. Administrative**	455,280	16,990				
c. LPN						
1. Direct Care	1,079,980	39,863				
2. Administrative**						
d. Aides and Attendants	1,778,493	115,263				
e. Physical Therapists	484,124	14,935				
f. Speech Therapists	192,180	4,206				
g. Occupational Therapists	415,370	11,267				
h. Recreation Workers	163,694	8,396				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	221,562	8,263				
n. Marketing						
o. Other (Specify)						
<i>A-13. Total Salary Expenditures</i>	6,935,455	320,559				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
 ** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
 *** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

**Schedule A1 - Salary Information for Operators/Owners; Administrators,
 Assistant Administrators and Other Related Parties***

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center				License No. 2182-C	Report for Year Ended 9/30/2017			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Not Applicable										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
Not Applicable										

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include all employment worked during the cost year.

Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Related Parties*

Name of Facility (as licensed) Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center				License No. 2182-C		Report for Year Ended 9/30/2017			Page 12	of 37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Linda P. Garcia (10/1/2016 - 09/30/2017)	121,637			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,100	A2			
Section IV - Assistant Administrators										

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include all other employment worked during the cost year.

*** If more than one Administrator is reported, include dates of employment for each.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/2017	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian.....	15,445	404				
2. Dentist.....	1,800	11				
3. Pharmacist.....	11,650	214				
4. Podiatrist.....						
5. Physical Therapy						
a. Resident Care.....	159,804	2,514				
b. Other.....						
6. Social Worker.....						
7. Recreation Worker.....						
8. Physicians						
a. Medical Director (entire facility).....	50,400	321				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**.....	226					
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care.....	7,848	54				
b. Other.....						
10. Occupational Therapist						
a. Resident Care.....						
b. Other.....						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	6,968	112				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides.....						
d. Other.....						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	254,141	3,629				

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

*** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

Report of Expenditures
Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis*

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center		License No. 2182-C	Report for Year Ended 9/30/2017	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Advanced Medical Personnel P.O. Box 392450 Pittsburgh, PA 15251-9450	Physical & Speech Therapy	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Mary Jane Leonetti, 245 Cherry Avenue Unit 21N Watertown, CT 06795	Dietician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Robert Badrigian, 5 South Main St, Suite 515 Branford, CT 06405	Dentist	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Omnicare/Value Health Care Services, Inc 525 Knotter Drive Cheshire, CT 06410	Pharmacist	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Access Therapies, P.O.Box 823461, Philadelphia, PA	Physical Therapy	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Alliance Medical Group Inc (Dr. Elser), 1801 W Olympic Blvd File 2201 Pasadena, CA 91199-	Medical Director, Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Franklin Medical Group / Dr. Neil Miller, 56 Franklin Street Waterbury, CT 06706	Medical Staff	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
ProHealth / Dr. Neil Miller, 3 Farm Glen Road Farmington, CT 06032	Medical Staff	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Athena Health Care Systems 135 South Road Farmington, CT 06032	MDS Fill-in	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Ownership	
Anne Worthington 14 Hockanum Glen Road Beacon Falls, CT 06403	Dietician (Fill In for Mary Jane Leonetti)	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
SDX Swallowing Diagnostics, 21 Waterville Road Avon, CT 06001	Speech Therapy	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Procure LTC Pharmacy of CT LTC, 110 BI- County Blvd Suite 121 Farmingdale, NY 11735	Pharmacist	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Ownership: Minority Interest	
		<input type="checkbox"/>	<input checked="" type="checkbox"/>		
		<input type="checkbox"/>	<input checked="" type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		

* Use additional sheets if necessary
 ** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/2017		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation.....	\$ 455,239	455,239			
2. Disability Insurance.....	\$				
3. Unemployment Insurance.....	\$ 90,887	90,887			
4. Social Security (F.I.C.A.).....	\$ 512,583	512,583			
5. Health Insurance.....	\$ 1,350,154	1,350,154			
6. Life Insurance (employees only) (not-owners and not-operators).....	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators).....	\$ 29,183	29,183			
8. Uniform Allowance.....	\$				
9. Other (<i>Specify</i>)..... See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 23,761	23,761			
d. Accounting and Auditing.....	\$ 28,825	28,825			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 5,372	5,372			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies.....	\$ 56,497	56,497			
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	\$ 26,018	26,018			
2. Cellular Phones.	\$ 1,700	1,700			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>).	\$ 250	250			
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$ 250	250			
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 794,934	794,934			
Subtotal	\$ 3,375,653	3,375,653			

* Facility should self-disallow the expense on Page 28 of the Cost Report.

(Carry Subtotals forward to next page)

C. Expenditures Other Than Salaries (cont'd) - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/2017		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	3,375,653	3,375,653			
1. Travel and Entertainment					
1. Resident Travel and Entertainment.....	\$				
2. Holiday Parties for Staff.....	\$ 5,374	5,374			
3. Gifts to Staff and Residents.....	\$ 10,851	10,851			
4. Employee Travel.....	\$ 1,437	1,437			
5. Education Expenses Related to Seminars and Conventions	\$ 5,698	5,698			
6. Automobile Expense (<i>not purchase or depreciation</i>)....	\$				
7. Other (<i>Specify</i>).....	\$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>).....	\$ 8,962	8,962			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$ 998	998			
3. Advertising Other (<i>Specify</i>)***.....	\$ 20,215	20,215			
See Attached Schedule					
4. Fund-Raising***.....	\$				
5. Medical Records.....	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***.....	\$				
7. Postage.....	\$ 7,900	7,900			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>)	\$ 8,586	8,586			
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions.....	\$ 859	859			
10. Contributions***	\$				
See Attached Schedule					
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**.....	\$ 152,457	152,457			
13. Other (<i>Specify</i>)	\$ 107,315	107,315			
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$ 3,706,305	3,706,305			

* Do not include Subscriptions, which should go in item 9.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 *** Facility should self-disallow the expense on Page 28 of the Cost Report.

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 20,215		
Total Other Advertising	\$ 20,215	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CHACF	\$ 8,586		
Total Dues	\$ 8,586	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Total Contributions	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	\$ 11,395		
Payroll Processing Fees	\$ 22,669		
Employee Physicals & Background Checks	\$ 19,662		
Data Processing Fees	\$ 45,165		
Utility Audit	\$ 355		
CMP2017-01-LTC-063	\$ 6,539		
State of CT Public Health Citation2017-53	\$ 1,530		
Total Other Administrative and General	\$ 107,315	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	License No. 2182-C	Report for Year Ended 9/30/2017	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	\$180,792	Contract Attached to a Prior Year	See Below
Allocation of the Above	\$119,323 \$28,927 \$32,543	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 18, Line 2C Pg 20, Line 5J
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	\$33,134	Admin/Gen - Other Exp	Pg 16, Line 12

* In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.

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C. Expenditures Other Than Salaries (cont'd) - Dietary Basis for Allocation of Costs
(See Note on Page 5)

Name of Facility		License No.	Report for Year Ended		Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center		2182-C	9/30/2017		18	37
Item	Total	CCNH	RHNS	(Specify)		
2. Dietary						
a. In-House Preparation & Service						
1. Raw Food.....	\$ 280,007	280,007				
2. Non-Food Supplies.....	\$ 19,841	19,841				
3. Other (Specify) _____	\$ 2,249	2,249				
Dishes = \$2,249						
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$					
c. Management Services**	\$ 28,927	28,927				
d. Other (Specify) _____	\$					
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 331,024	331,024				
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)		
G. Resident Meals: Total no. of meals served per day:*	360	360				
H. Is cost of employee meals included in 2E?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No				
I. Did you receive revenue from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.			
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, specify cost. = \$200			
L. Is any revenue collected from these people?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.			
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.			
O. Is any revenue collected from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.			
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)						

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

C. Expenditures Other Than Salaries (cont'd) Laundry-Basis for Allocation of Costs
(See Note on Page 5)

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center		License No. 2182-C	Report for Year Ended 9/30/2017	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$			
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.			
		Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.			
		Amt. \$			
4. Repair and/or purchase of linens.***		Lbs.			
		Amt. \$	13,035	13,035	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Management Services**		\$			
d. Other (Specify) Supplies = \$9,697		\$	9,697	9,697	
3E. Total Laundry Expenditures (3a + b + c + d)		\$	22,732	22,732	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?			<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.
H. Did you receive revenue from employees?			<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.
I. Where is the revenue received reported in the Cost Report?			(Page/Line Item)		
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?			<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.
K. Did you receive revenue from these people?			<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.
L. Where is the revenue received reported in the Cost Report?			(Page/Line Item)		

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
 All allocations should add to total recorded in 3E.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 *** Pounds of Laundry only required for multi-level facilities.

**C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care
 Basis for Allocation of Costs (See Note on Page 5)**

Name of Facility		License No.	Report for Year Ended		Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center		2182-C	9/30/2017		20	37
Item		Total	CCNH	RHNS	(Specify)	
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	39,918	39,918			
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel					
	Amt. \$					
c. Management Services*		\$				
d. Other (<i>Specify</i>)		\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)...		\$ 39,918	39,918			
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy.....	\$					
2. Purchased from <i>Omni Care through 12/31/16 Procure LTC effective 1/1/17</i>	\$	386,241	386,241			
b. Medicine Cabinet Drugs.....	\$	21,360	21,360			
c. Medical and Therapeutic Supplies.....	\$	288,182	288,182			
d. Ambulance/Limousine***	\$	14,042	14,042			
e. Oxygen						
1. For Emergency Use.....	\$					
2. Other***	\$	58,255	58,255			
f. X-rays and Related Radiological Procedures***	\$	26,731	26,731			
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$					
h. Laboratory***	\$	41,920	41,920			
i. Recreation.....	\$	16,071	16,071			
j. Other (Specify)**** <i>See Attached Schedule</i>	\$	185,581	185,581			
5K. Total Resident Care Expenditures (5a - 5j).....	\$	1,038,383	1,038,383			

* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Report of Expenditures
Schedule C-2 - Individuals or Firms Providing Services by Contract *

Name of Facility			License No.	Report for Year Ended			Page	of		
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center			2182-C	9/30/2017			21	37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADP	100 Corporate Drive, Windsor, CT 06095	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Payroll Processing	18,745			16	m13
CT Waste Processing	P.O. Box 415 Plainville, CT 06062	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Rubbish Removal	26,104			22	6f
Omnicare	525 Knotter Dr, Cheshire, CT	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Pharmacy Services	91,515			20	12, 2C, 5J
Procure LTC Pharmacy of CT LLC	121 Farmingdale, NY 11735	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Owners Minority Interest	Pharmacy Services	315,280			20	5a2
Commercial Property Services	PO Box 425, Watertown, CT 06795	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Snow Removal Services	19,209			22	6f
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

C. Expenditures Other Than Salaries (cont'd) - Maintenance and Property

Name of Facility	License No.	Report for Year Ended			Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance..... \$	75,282	75,282				
b. Heat..... \$	60,253	60,253				
c. Light & Power..... \$	154,350	154,350				
d. Water..... \$	48,586	48,586				
e. Equipment Lease (<i>Provide detail on page 6</i>)..... \$	31,987	31,987				
f. Other (<i>itemize</i>)..... \$	75,385	75,385				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)..... \$	445,843	445,843				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements..... \$	1,230	1,230				
b. Building & Building Improvements..... \$	290,118	290,118				
c. Non-Movable Equipment..... \$	13,895	13,895				
d. Movable Equipment..... \$	67,636	67,636				
*7e. Total Depreciation Costs (7a + b + c + d)..... \$	372,879	372,879				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense..... \$						
b. Mortgage Expense..... \$	15,438	15,438				
c. Leasehold Improvements..... \$						
d. Other (<i>Specify</i>)..... \$	1,277	1,277				
*8e. Total Amortization Costs (8a + b + c + d)..... \$	16,715	16,715				
9. Rental payments on leased real property less real estate taxes included in item 10b..... \$						
10. Property Taxes						
a. Real estate taxes paid by owner..... \$	216,913	216,913				
b. Real estate taxes paid by lessor..... \$						
c. Personal property taxes..... \$	22,188	22,188				
11. Total Property Expenses (7e + 8e + 9 + 10)..... \$	628,695	628,695				

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	\$ 9,621		
Rubbish Removal	\$ 26,104		
Snow Removal	\$ 19,209		
Supplies	\$ 20,451		
Total Other Repairs and Maintenance	\$ 75,385	\$ -	\$ -

Depreciation Schedule

Name of Facility		License No.			Report for Year Ended			Page	of				
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center		2182-C			9/30/2017			23	37				
Property Item		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals				
A. Land Improvements													
1. Acquired prior to this report period		162,495		162,495	154,675	S/L	Various	1,230					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal.....									1,230				
B. Building and Building Improvements													
1. Acquired prior to this report period		9,373,778		9,373,778	5,183,891	S/L	Various	289,550					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)		12,721		12,721		S/L	Various	568					
B-4. Subtotal.....									290,118				
C. Non-Movable Equipment													
1. Acquired prior to this report period		321,793		321,793	251,301	SL	Various	13,895					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal.....									13,895				
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year								
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period				9	2016	979,685		979,685	714,480	S/L	Various	64,293	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)				9	2017	35,992		35,992		S/L	Various	3,343	
D-3. Subtotal.....													67,636
E. Total Depreciation													372,879

Amortization Schedule*

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center			License No. 2182-C		Report for Year Ended 9/30/2017			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal.....									
B. Mortgage Expense									
1. Finance Fees - Santander	9	2016	6 yrs	91,342		SL	0	15,438	
2.									
3.									
B-4. Subtotal.....									15,438
C. Leasehold Improvements and Other (Specify)									
1. Acquired prior to this report period		2016	Various	1,127,832	150,746		Var	1,277	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)		2017	Various				Var		
C-4. Subtotal.....									1,277
D. Total Amortization									16,715

* Straight-line method must be used.

** Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility		License No.		Report for Year Ended				Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center		2182-C		9/30/2017				24A	37
C. Leasehold Improvements (Specify)									
1. Acquired prior to this report period		2016							
2. Disposals (attach schedule)									
3. Acquired during this report period		2017							
C-4. Subtotal.....									
C. Other (Specify)									
1. Bed License Purchase		9	1997	15 yrs	1,127,500	150,746	None	None	
2. Wound Vac Warranty		7	2014	2	332		None	None	1,277
C-4. Subtotal.....								1,277	
Total Acquired prior to this report period		2016	Various		1,127,832	150,746		Var	1,277
Total Disposals									
Total Acquired during this report period		2017	Various					Var	

C. Expenditures Other Than Salaries (cont'd) - Property Questionnaire

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	License No. 2182-C	Report for Year Ended 9/30/2017	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party*? Yes No If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure	11/01/93			
5. Total Licensed Bed Capacity	126			
6. Square Footage				
7. Acquisition Cost				
a. Land	546,300			
b. Building	5,739,513			
Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Variable			
b. Date Mortgage Obtained	08/15/16			
c. Interest Rate for the Cost Year	3.31%			
d. Term of Mortgage (number of years)	6			
e. Amount of Principal Borrowed	10,300,000			
f. Principal balance outstanding as of 9/30/2017	10,010,025			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

C. Expenditures Other Than Salaries (cont'd) - Interest

Name of Facility		License No.	Report for Year Ended		Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center		2182-C	9/30/2017		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage.....			\$ 343,259	343,259		
Name of Lender		Rate				
Sovereign Bank		Variable				
Address of Lender						
Reading, PA						
2. Second Mortgage.....			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage.....			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage.....			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount.....			\$			
2. Loan Origination Date.....						
3. Interest Rate %.....						
4. Term.....						
5. CHEFA Interest Expense.....						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$ 343,259	343,259		

(Carry Subtotals forward to next page)

C. Expenditures Other Than Salaries (cont'd) - Interest and Insurance

Name of Facility		License No.		Report for Year Ended		Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center		2182-C		9/30/2017		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				343,259	343,259		
12. C. Movable Equipment							
1. Automotive Equipment..... \$							
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)..... \$							
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)..... \$							
12. D. Other Interest Expense (Specify)..... \$				20,385	20,385		
Vender Interest = \$20,385							
13. Total All Interest Expense (12B7 + 12C3 + 12D)..... \$				363,644	363,644		
14. Insurance							
a. Insurance on Property (buildings only)..... \$				82,152	82,152		
b. Insurance on Automobiles..... \$							
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)..... \$							
2. Fire and Extended Coverage..... \$							
3. Other (Specify)..... \$							
14d. Total Insurance Expenditures (14a + b + c).... \$				82,152	82,152		
15. Total All Expenditures (A-13 thru C-14)..... \$				13,848,292	13,848,292		

D. Adjustments to Statement of Expenditures

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center				License No. 2182-C	Report for Year Ended 9/30/2017	Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs.....	\$			
2.			Salaries not related to Resident Care....	\$ 3,234	3,234		
3.	10	A12g	Occupational Therapy.....	\$ 415,370	415,370		
4.	Var	Var	Other - See attached Schedule.....	\$ 3,234	3,234		
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **.....	\$ 226	226		
6.			Occupational Therapy.....	\$			
7.			Other - See attached Schedule.....	\$			
Pages 15 & 16 - Administrative and General							
8.	15	1a9	Discriminatory Benefits.....	\$			
9.	15	1c	Bad Debts.....	\$ 23,761	23,761		
10.	15	1d&e	Accounting & Legal.....	\$ 3,936	3,936		
11.			Telephone.....	\$			
12.	15	1h2	Cellular Telephone.....	\$ 780	780		
13.			Life insurance premiums on the life of Owners, Partners, Operators.....	\$			
14.	16	13	Gifts, flowers and coffee shops.....	\$ 10,851	10,851		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees.....	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative....	\$			
17.			Automobile Expense (e.g. personal use).	\$			
18.	16	m2&3	Unallowable Advertising *.....	\$ 21,213	21,213		
19.	15	1j&k1 &2	Income Tax / Corporate Business Tax...	\$ 250	250		
20.			Fund Raising / Contributions.....	\$			
21.	16	m12	Unallowable Management Fees.....	\$ 2,164	2,164		
	18	2c		\$ 525	525		
	20	5j		\$ 590	590		
22.			Barber and Beauty.....	\$			
23.	Var	Var	Other - See attached Schedule.....	\$ 20,066	20,066		
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents.....	\$ 200	200		
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents.....	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees and others who are not residents.....	\$			
Subtotal (Items 1 - 26)				\$ 506,400	506,400		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

D. Adjustments to Statement of Expenditures (cont'd)

Name of Facility			License No.	Report for Year Ended	Page	of	
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center			2182-C	9/30/2017	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 506,400	506,400		
Page 20 - Resident Care Supplies ***							
27.	20	5a1&2	Prescription Drugs.....	\$ 386,241	386,241		
28.	20	5d	Ambulance/Limousine.....	\$ 14,042	14,042		
29.	20	5f	X-rays, etc.....	\$ 26,731	26,731		
30.	20	5h	Laboratory.....	\$ 41,920	41,920		
31.	20	5c	Medical Supplies.....	\$ 15,158	15,158		
32.	20	5e2	Oxygen (non emergency).....	\$ 58,255	58,255		
33.	20	5j	Occupational Therapy.....	\$ 3,108	3,108		
34.	Var	Var	Other - See Attached Schedule.....	\$ 45,204	45,204		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation				
	Var	Var	See Attached Schedule.....	\$ 3,142	3,142		
36.			Depreciation on Unallowable Motor Vehicles.....	\$			
37.			Unallowable Property and Real Estate Taxes.....	\$			
38.			Rental of Building Space or Rooms.....	\$			
39.			Other - See Attached Schedule.....	\$			
Page 27 - Insurance							
40.			Mortgage Insurance.....	\$			
41.			Property Insurance.....	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities.....	\$			
43.	20	5	Radio and Television Revenue.....	\$ 12,094	12,094		
44.			Vending Machine Revenue.....	\$			
45.			Purchase Discounts and Allowances....	\$			
46.			Duplications of functions or services....	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest.....	\$			
48.	30	ivs	Interest Income on Accounts Rec.....	\$ 187	187		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule.....	\$			
Not For Profit Providers Only							
50.	Var	Var	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule.....	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 1,112,482	1,112,482		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5b	E-Box	22,717		
20	5j	Medical Equipment Rental	22,487		
Total Other Ancillary Costs			\$ 45,204	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Carryforward Equipment AJE	3,142		
Total Excess Movable Equipment Depreciation			3,142		

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Property Adjustments					

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Adjustments			\$ -	\$ -	\$ -

Beacon Brook Moveable Equipment Carryforward Schedule

Cost Year	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Totals		
	Excess Over CON Adj #1	Excess Over CON Adj #2	Dryer Reclass	Dryer Reclass	2000 Bed Addition Adj #1	2000 Bed Addition Adj #2	2014 Joems Bed Credit	2015 cost reports - tv's	2017 cost report TV's		
Cost Term	\$ 26,458	\$ 12,245	\$ (1,583)	\$ 1,583	\$ 21,632	\$ 55,977	\$ 8,907	\$ 691	\$ 24,102	\$ 150,012	
	\$ 5	\$ 10	\$ 10	\$ 10	\$ 10	\$ 15	\$ 15	\$ 5	\$ 5		
			ADD BACK								
1995 Deprec	\$ 2,646	\$ 612								\$ 3,258	
1995 Book Value	\$ 23,812	\$ 11,633								\$ 35,445	
1996 Deprec	\$ 5,292	\$ 1,224	\$ (79)							\$ 6,437	
1996 Book Value	\$ 18,520	\$ 10,409	\$ (1,504)							\$ 27,425	
1997 Deprec	\$ 5,292	\$ 1,224	\$ (158)	\$ 79						\$ 6,437	
1997 Book Value	\$ 13,228	\$ 9,185	\$ (1,346)	\$ 1,504						\$ 22,571	
1998 Deprec	\$ 5,292	\$ 1,224	\$ (158)	\$ 158						\$ 6,516	
1998 Book Value	\$ 7,936	\$ 7,961	\$ (1,188)	\$ 1,346						\$ 16,055	
1999 Deprec	\$ 5,292	\$ 1,224	\$ (158)	\$ 158						\$ 6,516	
1999 Book Value	\$ 2,644	\$ 6,737	\$ (1,029)	\$ 1,188						\$ 9,540	
2000 Deprec	\$ 2,644	\$ 1,224	\$ (158)	\$ 158	\$ 2,163	\$ 3,732				\$ 9,763	
2000 Book Value	\$ -	\$ 5,513	\$ (871)	\$ 1,029	\$ 19,469	\$ 52,245				\$ 77,385	
2001 Deprec	\$ 1,224	\$ (158)	\$ 158	\$ 158	\$ 2,163	\$ 3,732				\$ 7,119	
2001 Book Value	\$ 4,289	\$ (713)	\$ 871	\$ 17,306	\$ 48,513					\$ 70,266	
2002 Deprec	\$ 1,224	\$ (158)	\$ 158	\$ 158	\$ 2,163	\$ 3,732				\$ 7,119	
2002 Book Value	\$ 3,065	\$ (554)	\$ 713	\$ 15,143	\$ 44,781					\$ 63,148	
2003 Deprec	\$ 1,224	\$ (158)	\$ 158	\$ 158	\$ 2,163	\$ 3,732				\$ 7,119	
2003 Book Value	\$ 1,841	\$ (396)	\$ 554	\$ 12,980	\$ 41,049					\$ 56,028	
2004 Deprec	\$ 1,224	\$ (158)	\$ 158	\$ 158	\$ 2,163	\$ 3,732				\$ 7,119	
2004 Book Value	\$ 617	\$ (238)	\$ 396	\$ 10,817	\$ 37,317					\$ 48,909	
2005 Deprec	\$ 617	\$ (158)	\$ 158	\$ 158	\$ 2,163	\$ 3,732				\$ 6,512	
2005 Book Value	\$ -	\$ (79)	\$ 238	\$ 8,654	\$ 33,585					\$ 42,398	
2006 Deprec	\$ (79)	\$ 158	\$ 158	\$ 2,163	\$ 3,732					\$ 5,974	
2006 Book Value	\$ -	\$ -	\$ 79	\$ 6,491	\$ 29,853					\$ 36,423	
2007 Deprec	\$ -	\$ -	\$ 79	\$ 2,163	\$ 3,732					\$ 5,974	
2007 Book Value	\$ -	\$ -	\$ -	\$ 4,328	\$ 26,121					\$ 30,449	
2008 Deprec	\$ -	\$ -	\$ -	\$ 2,163	\$ 3,732					\$ 5,895	
2008 Book Value	\$ -	\$ -	\$ -	\$ 2,165	\$ 22,389					\$ 24,554	
2009 Deprec	\$ -	\$ -	\$ -	\$ 2,165	\$ 3,732					\$ 5,897	
2009 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 18,657					\$ 18,657	
2010 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 3,732					\$ 3,732	
2010 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 14,925					\$ 14,925	
2011 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 3,732					\$ 3,732	
2011 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 11,193					\$ 11,193	
2012 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 3,732					\$ 3,732	
2012 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 7,461					\$ 7,461	
2013 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 3,732					\$ 3,732	
2013 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 3,729					\$ 3,729	
2014 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 3,729	\$ 594				\$ 4,323	
2014 Book Value	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 8,313				\$ 8,313	
2015 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 594	\$ 69				\$ 663	
2015 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 7,719	\$ 622				\$ 8,341	
2016 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 594	\$ 138				\$ 732	
2016 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 7,125	\$ 484				\$ 7,609	
2017 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 594	\$ 138	\$ 2,410			\$ 3,142	
2017 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 6,531	\$ 346	\$ 21,692			\$ 28,569	
2018 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 594	\$ 138	\$ 4,820			\$ 5,552	
2018 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 5,937	\$ 208	\$ 16,872			\$ 23,017	
2019 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 594	\$ 138	\$ 4,820			\$ 5,552	
2019 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 5,343	\$ 70	\$ 12,052			\$ 17,465	
2020 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 594	\$ 70	\$ 4,820			\$ 5,484	
2020 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 4,749	\$ (0)	\$ 7,232			\$ 11,981	
2021 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 594	\$ -	\$ 4,820			\$ 5,414	
2021 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 4,155	\$ -	\$ 2,412			\$ 6,567	
2022 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 594	\$ -	\$ 2,412			\$ 3,006	
2022 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 3,561	\$ -	\$ (0)			\$ 3,561	
2023 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 594	\$ -	\$ -			\$ 594	
2023 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 2,967	\$ -	\$ -			\$ 2,967	
2024 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 594	\$ -	\$ -			\$ 594	
2024 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 2,373	\$ -	\$ -			\$ 2,373	
2025 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 594	\$ -	\$ -			\$ 594	
2025 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 1,779	\$ -	\$ -			\$ 1,779	
2026 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 594	\$ -	\$ -			\$ 594	
2026 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 1,185	\$ -	\$ -			\$ 1,185	
2027 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 594	\$ -	\$ -			\$ 594	
2027 Book Value	\$ -	\$ -	\$ -	\$ -	\$ 591	\$ -	\$ -			\$ 591	
2028 Deprec	\$ -	\$ -	\$ -	\$ -	\$ 591	\$ -	\$ -			\$ 591	
2028 Book Value	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			\$ -	

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/2017			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>).....	\$ 18,145,078	18,145,078				
b. Medicaid Room and Board Contractual Allowance **.....	\$ (9,936,819)	(9,936,819)				
2. a. Medicaid (<i>All other states</i>).....	\$					
b. Other States Room and Board Contractual Allowance **.....	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,359,570	2,359,570				
b. Medicare Room and Board Contractual Allowance **.....	\$ 533,263	533,263				
4. a. Private-Pay Residents and Other.....	\$ 1,996,792	1,996,792				
b. Private-Pay Room and Board Contractual Allowance **.....	\$ (226,367)	(226,367)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare.....	\$ 307,955	307,955				
b. Prescription Drugs - Medicare Contractual Allowance **.....	\$ (307,955)	(307,955)				
c. Prescription Drugs - Non-Medicare.....	\$ 249,529	249,529				
d. Prescription Drugs - Non-Medicare Contractual Allowance **.....	\$ (249,529)	(249,529)				
2. a. Medical Supplies - Medicare.....	\$ 2,558	2,558				
b. Medical Supplies - Medicare Contractual Allowance **.....	\$					
c. Medical Supplies - Non-Medicare.....	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **.....	\$					
3. a. Physical Therapy - Medicare.....	\$ 1,142,825	1,142,825				
b. Physical Therapy - Medicare Contractual Allowance **.....	\$ (860,293)	(860,293)				
c. Physical Therapy - Non-Medicare.....	\$ 410,000	410,000				
d. Physical Therapy - Non-Medicare Contractual Allowance **.....	\$ (410,000)	(410,000)				
4. a. Speech Therapy - Medicare.....	\$ 392,060	392,060				
b. Speech Therapy - Medicare Contractual Allowance **.....	\$ (308,082)	(308,082)				
c. Speech Therapy - Non-Medicare.....	\$ 160,615	160,615				
d. Speech Therapy - Non-Medicare Contractual Allowance **.....	\$ (160,615)	(160,615)				
5. a. Occupational Therapy - Medicare.....	\$ 913,810	913,810				
b. Occupational Therapy - Medicare Contractual Allowance **.....	\$ (740,724)	(740,724)				
c. Occupational Therapy - Non-Medicare.....	\$ 388,200	388,200				
d. Occupational Therapy - Non-Medicare Contractual Allowance **.....	\$ (388,200)	(388,200)				
6. a. Other (<i>Specify</i>) - Medicare.....	\$					
b. Other (<i>Specify</i>) - Non-Medicare.....	\$ (25,264)	(25,264)				
III Total Resident Revenue (Section I thru Section II.).....	\$ 13,388,407	13,388,407				
IV. Other Revenue*						
1. Meals sold to guests, employees & others.....	\$					
2. Rental of rooms to non-residents.....	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services.....	\$					
5. Interest Income (<i>Specify</i>)	\$ 187	187				
6. Private Duty Nurses' Fees.....	\$					
7. Barber, Coffee, Beauty and Gift shops.....	\$					
8. Other (<i>Specify</i>).....	\$ 1,095	1,095				
V. Total Other Revenue (1 thru 8).....	\$ 1,282	1,282				
VI. Total All Revenue (III + V).....	\$ 13,389,689	13,389,689				

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts..

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Retroactives	\$ (25,264)		
Total Other Resident Revenue		\$ (25,264)	\$ -	\$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
pg 31, L A2	Interest on A/R	N/A	\$ 187		
Total Interest Income			\$ 187	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
NA	Bad Debt Recoveries	\$ 1,095		
Total Other Revenue		\$ 1,095	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>).....			\$	133,830
2. Resident Accounts Receivable (Less Allowance for Bad Debts).....			\$	1,618,034
3. Other Accounts Receivable (Excluding Owners or Related Parties).....			\$	
4. Inventories.....			\$	20,564
5. Prepaid Expenses.....			\$	262,185
a. Prepaid Insurance	232,033			
b. Prepaid Expense	3,853			
c. Prepaid Interest	18,443			
d. A/R Related Parties	7,856			
6. Interest Receivable.....			\$	
7. Medicare Final Settlement Receivable.....			\$	
8. Other Current Assets (<i>itemize</i>).....			\$	8,213
Mortgage Reserve Fund	8,213			
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,042,826
B. Fixed Assets				
1. Land.....			\$	546,300
2. Land Improvements	*Historical Cost.....	162,495	\$	6,591
	Accum. Depreciation	(155,904) Net.....		
3. Buildings	*Historical Cost.....	9,386,501	\$	3,912,489
	Accum. Depreciation	(5,474,012) Net.....		
4. Leasehold Improvements	*Historical Cost.....		\$	
	Accum. Depreciation	Net.....		
5. Non-Movable Equipment	*Historical Cost.....	321,794	\$	56,598
	Accum. Depreciation	(265,196) Net.....		
6. Movable Equipment	*Historical Cost.....	987,109	\$	204,992
	Accum. Depreciation	(782,117) Net.....		
7. Motor Vehicles	*Historical Cost.....		\$	
	Accum. Depreciation	Net.....		
8. Minor Equipment-Not Depreciable.....			\$	
9. Other Fixed Assets (<i>itemize</i>).....			\$	28,569
Carryforward Equipment Adjustment	28,569			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	4,755,539

* Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$	6,798,365
C. Leasehold or like property recorded for Equity Purposes.				
1. Land.....			\$	
2. Land Improvements				
	*Historical Cost.....	_____		
	Accum. Depreciation	_____	Net.....	\$
3. Buildings				
	*Historical Cost.....	_____		
	Accum. Depreciation	_____	Net.....	\$
4. Non-Movable Equipment				
	*Historical Cost.....	_____		
	Accum. Depreciation	_____	Net.....	\$
5. Movable Equipment				
	*Historical Cost.....	_____		
	Accum. Depreciation	_____	Net.....	\$
6. Motor Vehicles				
	*Historical Cost.....	_____		
	Accum. Depreciation	_____	Net.....	\$
7. Minor Equipment-Not Depreciable.....			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits.....			\$	
2. Escrow Deposits.....			\$	
3. Organization Expense				
	*Historical Cost.....	_____		
	Accum. Depreciation	_____	Net.....	\$
4. Goodwill (Purchased Only).....			\$	
5. Investments Related to Resident Care (<i>itemize</i>).....			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>).....			\$	2,569,667
	Unamortized Bed License	2,497,302		
	Deferred Finance Fees	72,365		
D-8. Total Investments and Other Assets (Lines D1 thru 7).....			\$	2,569,667
D-9. Total All Assets (Lines A9 + B10 + C8 + D8).....			\$	9,368,032

* Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

G. Balance Sheet (cont'd)

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	License No. 2182-C	Report for Year Ended 9/30/2017	Page 34	of 37
Account			Amount	
			Total Brought Forward:	
			3,282,569	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>).....\$				
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable.....				\$ 10,010,025
3. Loans from Owners or Related Parties (<i>itemize</i>).....				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>).....				\$ 234,600
Santander Swap Liability		234,600		
B-5. Total Long-Term Liabilities (Lines B1 thru 4).....				\$ 10,244,625
C. Total All Liabilities (Lines A-13 + B-5).....				\$ 13,527,194

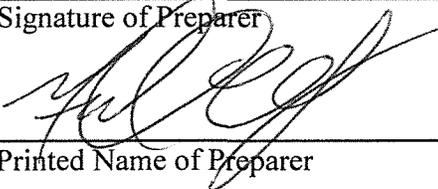
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/2017	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land.....			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized.....			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>) ..			\$	
4. Reserve for leasehold real properties on which fair rental value is based.....			\$	
5. Reserve for funds set aside as donor restricted.....			\$	
6. Total Reserves.....			\$	
B. Net Worth				
1. Owner's Capital.....			\$	
2. Capital Stock.....			\$	
3. Paid-in Surplus.....			\$	(1,557,427)
4. Treasury Stock.....			\$	
5. Cumulated Earnings.....			\$	(2,143,132)
6. Gain or Loss for Period				
	10/1/2016	thru	9/30/2017	\$ (458,603)
7. Total Net Worth.....			\$	(4,159,162)
C. Total Reserves and Net Worth			\$	(4,159,162)
D. Total Liabilities, Reserves, and Net Worth			\$	9,368,032

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/2017	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	(3,067,374)
B. Total Revenue (From Statement of Revenue Page 30)			\$	13,389,689
C. Total Expenditures (From Statement of Expenditures Page 27)			\$	13,848,292
D. Net Income or Deficit.....			\$	(458,603)
E. Balance.....			\$	(3,525,977)
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2016 Pension Reversal			9,000	
2016 Health Insurance			17,618	
Santander Swap Liability			(234,600)	
			(425,203)	
2. Other (<i>itemize</i>)				
F-3. Total Additions.....			\$	(633,185)
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>).....			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>).....			\$	
Purpose		Amount		
3. Total Deductions.....			\$	
H. Balance at End of Period			\$	(4,159,162)
09/30/17				

I. Preparer's/Reviewer's Certification

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	License No. 2182-C	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>				
CCNH	RHNS	Other (<i>Specify</i>)		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer 	Title CFO	Date Signed 2/9/18		
Printed Name of Preparer Athena Health Care Associates, Inc				
Address 135 South Road Farmington, CT 06032		Phone Number (860) 751-3900		

Cost report forms generated by Athena Health Care Associates, Inc as approved in letter dated 12/11/13.